

# Primary Care Practice State-Regulated Payer Electronic Health Record Adoption Incentive Payment Request Form

## Payment Request Instructions

Please **read all information** regarding the State-regulated payer electronic health record (EHR) incentive program, including eligibility, and other program requirements on the website at the following link before completing this payment request: [mhcc.dhmd.maryland.gov/hit/ehr/Pages/stateincentive/stateehrincentive.aspx](http://mhcc.dhmd.maryland.gov/hit/ehr/Pages/stateincentive/stateehrincentive.aspx).

This *Primary Care Practice State-Regulated Payer EHR Adoption Incentive Payment Request Form* is comprised of four parts. Part I captures primary care practice information. Part II is used to calculate the *Base Incentive*. Part III captures eligible *Additional Incentive* information. Part IV is a signed attestation to confirm the information contained in the payment request is correct.

Eligible primary care practices must submit the *State-Regulated EHR Adoption Incentive Payment Request Form*, including required documentation, to each payer to which it is requesting payment.

**NOTE:** You are required to answer all questions unless otherwise noted. Select attachments are required. Incomplete forms will be returned to the primary care practice.

## PART I – PRIMARY CARE PRACTICE INFORMATION

- Name of State-regulated payer (payer) to which this payment request is being submitted (*select only one*):
 

Aetna, Inc.	Coventry Health Care
CareFirst BlueCross BlueShield	Kaiser Permanente
CIGNA Health Care Mid-Atlantic Region	UnitedHealthcare, MidAtlantic Region
- Attach a copy of the State-Regulated Payer EHR Adoption Incentive Application Acknowledgement Letter from the payer. All attachments should include your practice name and tax ID#.**
- Primary Care Practice Name:
 

Street:	Street 2 (if applicable):	
City:	State:	Zip:
Area Code/Telephone:	Primary care practice tax identification number:	
Organization national provider identification number:		
- Identify the person to contact at the primary care practice for information concerning this payment request:
 

Name:	Title:
E-mail Address:	Area Code/Telephone:
- Include the following information for the primary care physicians within your practice(*add additional pages as attachments if needed. All attachments should include your practice name and tax ID.*):

Physician Name	Specialty	NPI #

## PART II – BASE INCENTIVE CALCULATION

1. Number of patients assigned to the practice, by the payer to which this payment request will be submitted, at the time of this payment request: \_\_\_\_\_ patients

\*If no patients are assigned by this payer, include the total number of patients, which are:

- a) Actively enrolled with the payer at the time of the payment request, and
- b) Who have been treated by the practice within the previous 24 months from the date of the payment request: \_\_\_\_\_ patients

*Incentives will be paid in cash unless the primary care practice and payer have agreed upon an incentive payment of equivalent value. **If the practice is requesting payment in cash, please skip to number three. If the practice is requesting an incentive payment of equivalent value, please answer number two below.***

2. If the primary care practice and payer have agreed upon a payment of equivalent value, please indicate the incentive type and percentage of the payment of equivalent value the primary care practice agreed to receive from the payer. *(Indicate all that apply)*

Incentive Type	%
Cash	
Increased reimbursement for specific services	
Gain-sharing arrangement	
Rewards for quality and efficiency	
In-kind payment	
Other (specify)	
Percentages must equal 100	Total

3. **Attach a list of the payer's patients to include in the *Base Incentive* calculation. Include first and last name, date of birth and member identification number. All attachments should include your practice name and tax ID#.** This information may be used to calculate the *Base Incentive*. A payer may exclude plan participants from the incentive calculation for a practice that was previously included in another practice's incentive calculation. Payers may exclude patients from the *Base Incentive* calculation who are enrolled in a self-insured health plan at the time of the payment request.

**Questions 4 and 5 below are optional and will not be used in determining your incentive amount.**

4. At the time of your payment request, do most of the professionals in the practice qualify for the Medicare EHR Incentive Program<sup>1</sup> under the *American Recovery and Reinvestment Act of 2009*?  
Yes                      No
5. At the time of your payment request, do most of the professionals in the practice qualify for the Medicaid EHR Incentive Program under the *American Recovery and Reinvestment Act of 2009*?  
Yes                      No

## PART III – ADDITIONAL INCENTIVE INFORMATION

The below questions will be used in part by payers to determine if the practice qualifies for an *Additional Incentive* payment. This part of the request can be submitted with the *Base Incentive* payment request or as

<sup>1</sup> For more information about the Medicare and Medicaid EHR Incentive Program, please visit:  
<https://www.cms.gov/ehrincentiveprograms/>.

a subsequent EHR adoption incentive payment request through December 31, 2014. If the practice chooses to request the *Additional Incentive* at a later date, Parts I, II, and IV must be included in the payment request for the *Base Incentive*. The regulation provides flexibility to payers to develop their own requirements for practices to qualify for an *Additional Incentive*. The primary care practice may qualify for an *Additional Incentive* if it achieves one of the following components in the immediate 90 days prior to this payment request. The primary care practice does not have to respond to each component question to be eligible for an *Additional Incentive*, but must respond to at least one to be considered for the *Additional Incentive*.

**Component 1. A contract between the primary care practice and a State-Designated management service organization (MSO) for EHR adoption or implementation**

1. Has the primary care practice contracted with an MSO<sup>2</sup> for EHR adoption or implementation services?

Yes – *proceed to Question a.*

No – *proceed to Component 2*

**Attach a copy of the MSO's State-Designation certificate or candidacy letter. All attachments should include your practice name and tax ID#.**

a) Date the practice began contracting with the State-Designated MSO:      Month      Year

b) *Optional* – Estimated State-Designated MSO monthly subscription fee: \$

**Component 2. A demonstration by the primary care practice of advanced use of an EHR system**

*If the primary care practice is not using these advanced functionalities of an EHR, proceed to Component 3.*

1. Indicate in the table below the advanced EHR functionality in use by your practice during the immediate 90 days prior to submitting this payment request.

EHR Functionality	Date of first use
	Actual/Expected (MM/DD/YY)
Clinical Decision Support	
Computerized Provider Order Entry	
Capturing and querying information relevant to health care quality	
Exchanging electronic health information with and integrating the information from other sources within the EHR	
Other: <i>(specify)</i>	
Other: <i>(specify)</i>	
Other: <i>(specify)</i>	

**Component 3. The participation by the primary care practice in a payer's quality improvement outcomes initiative and its achievement of the established performance goals**

1. Are you currently participating in a Quality Improvement Outcomes program(s) with the payer and has your practice achieved established performance goals?

Yes – *see comment below*

No – *proceed to PART IV*

**Attach documentation that supports your answer. All attachments should include your practice name and tax ID#.**

<sup>2</sup> An organization that has received recognition by the Maryland Health Care Commission (MHCC) as a State-Designated MSO or an entity that is in Candidacy status for State Designation. For a listing of MSOs, please visit: [http://mhcc.dhmdh.maryland.gov/hit/mso/Pages/mso\\_main.aspx](http://mhcc.dhmdh.maryland.gov/hit/mso/Pages/mso_main.aspx).

## PART IV – ATTESTATION

I hereby certify that I am an authorized agent of the reporting primary care practice and verify that the information submitted in this *EHR Adoption Incentive Payment Request Form*, is true and correct, to the best of my knowledge, information, and belief.

\_\_\_\_\_  
Name and Title of Authorized Primary Care Practice Representative

\_\_\_\_\_  
Signature of Authorized Primary Care Practice Representative

\_\_\_\_\_  
Date

*Entering an electronic signature or typing a name in the signature box above is the equivalent of a physical signature.*

### THANK YOU FOR COMPLETING THE PAYMENT REQUEST

## BEFORE YOU SUBMIT THE PAYMENT REQUEST

Be sure this payment request is complete by using this check list.

- ☐ Did you complete all questions in Part I, unless otherwise noted? *(needed for each payment request submission)*
- ☐ Did you complete all questions in Part II? *(needed when requesting the Base Incentive)*
- ☐ Did you indicate the appropriate components for the *Additional Incentive* in PART III? *(needed when requesting Additional Incentives)*
- ☐ Did you complete and sign the ATTESTATION by an authorized primary care practice representative?
- ☐ Did you attach a copy of State-Regulated Payer EHR Adoption Incentive Application Acknowledgement Letter from the payer? *(All attachments should include your practice name and tax ID#).*
- ☐ Did you attach a list of patients on the practice's panel, including first and last name, member identification number, and date of birth? If no patients are assigned by the payer, did you include the total number of patients which are actively enrolled with the payer at the time of the payment request, and who have been treated by the practice within the previous 24 months from the date of this payment request? *(All attachments should include your practice name and tax ID#)*
- ☐ If you answered yes to Component 1 under Part III, did you attach a copy of the MSO's State-Designation certificate or candidacy letter? *(All attachments should include your practice name and tax ID#)*
- ☐ If you answered yes to Component 2 under Part III, did you include which functions you were using and the date(s) implemented?
- ☐ If you answered yes to Component 3, under Part III, did you attach documentation of achievement of the payer's quality improvement outcomes initiative and the established performance goals? *(All attachments should include your practice name and tax ID#)*

## RETURN COMPLETED PAYMENT REQUEST

Please return completed payment request to the appropriate payer using the information provided below. The following address and contact information was provided by each payer. **Questions regarding your payment request should be directed to the payer using the following contact information.**

**Aetna, Inc.**

Maryland EHR Incentives  
509 Progress Drive  
Suite 118  
Linthicum, MD 21090  
Fax: (860) 975-9223  
[MarylandEHRIncentives@aetna.com](mailto:MarylandEHRIncentives@aetna.com)

**Coventry Health Care**

Attn: Provider Relations Department – Dolores Shores  
750 Prides Crossing, Suite 300  
Newark, DE 19713  
Phone: (800) 727-9951, ext. 2031145  
Fax 866-602-1246  
[dtshores@cvy.com](mailto:dtshores@cvy.com)

**CareFirst BlueCross BlueShield**

External Mandates, Mailstop: 01-301  
10455 Mills Run Circle  
Owings Mills, MD 21117  
C/O EHR Incentive Coordinator  
Fax 410-505-2445  
[EHRIncentiveCoordinator@carefirst.com](mailto:EHRIncentiveCoordinator@carefirst.com)

**Kaiser Permanente**

Provider Contracting and Network Management  
2101 E. Jefferson St.  
Rockville, MD 20852  
Phone: (301) 816-6564  
Fax: (301) 388-1700  
[Provider.Relations@kp.org](mailto:Provider.Relations@kp.org)

**CIGNA Health Care Mid-Atlantic Region**

Contracting, Electronic Health Records  
Fax: (888) 208-7173

**UnitedHealthcare, MidAtlantic Region**

Attention: MD EHR – Lisa Kahl  
800 King Farm Blvd, Suite 600  
Rockville, MD 20850  
Fax: (855) 740-9924  
[Md\\_ehr\\_incentive@uhc.com](mailto:Md_ehr_incentive@uhc.com)

## WHAT TO EXPECT NEXT

The payer will review the *EHR Adoption Incentive Payment Request Form* and may request additional information from the primary care practice to validate their EHR adoption incentive claim. After review, the payer will process and pay in full the adoption incentive within 90 days of receiving an EHR adoption incentive payment request as applicable. A payer will notify the primary care practice in writing concerning the amount of the EHR adoption incentive requested, how the payer will distribute the EHR adoption incentive to the primary care practice, and the time period over which it will be distributed.

Please note that a practice that has received a payer EHR adoption incentive before October 1, 2011 is only eligible to receive the difference between the payer's incentive and the maximum value of the EHR adoption incentive under this program.

**Questions regarding your payment request should be directed to the payer.**

## GLOSSARY

**Additional Incentive** - an adoption incentive not to exceed \$7,500 or an incentive of equivalent value above the *Base Incentive* awarded on a one-time basis to a primary care practice that meets additional criteria in the use and adoption of electronic health records including: a) contracts with a State-Designated MSO for EHR adoption or implementation services; b) demonstrates advanced use of EHRs; c) participates in the payer's quality improvement outcomes initiative, and achieves the performance goals established by the payer. Payers may implement a variety of approaches in calculating the *Additional Incentive* and determining a practice's qualification as it relates to advanced use of an EHR. Please contact the payer for details regarding its *Additional Incentive* calculation criteria.

**Base Incentive** - an adoption incentive not to exceed \$7,500 or an incentive of equivalent value awarded on a one-time basis to a primary care practice that is based on a per patient amount applied to the total number of the payer's member patients who are treated by the primary care practice. A payer may exclude plan participants from the incentive calculation for a practice that was previously included in another practice's incentive calculation. Payers may exclude patients from the *Base Incentive* calculation who are enrolled in a self-insured health plan at the time of the payment request.

**Electronic health record (EHR)** - an EHR system certified by an authorized testing and certification body designated by the Office of the National Coordinator for Health Information Technology and: 1) contains health-related information on an individual that includes patient demographic and clinical health information; 2) has the capacity to: provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and 3) exchange and integrate electronic health information from other sources.

**EHR adoption incentive** - a cash payment, or a payment incentive of equivalent value agreed upon by the primary care practice and payer, that an eligible primary care practice can receive from a payer to assist the primary care practice in adopting and implementing an electronic health record.

**Incentive of equivalent value** – a practice may choose a non-cash incentive, agreed upon with the payer, that includes any of the following: specific services; gain-sharing arrangements; reward for quality and efficiency; in-kind payment; or other items or services that can be assigned a specific monetary value.

**Management service organization (MSO)** - an organization that offers one or more hosted EHR solutions and other technical assistance services to health care providers and has received recognition by the Maryland Health Care Commission as a State-Designated MSO or has applied with the Maryland Health Care Commission for recognition as a State-Designated MSO and has been granted Candidacy Status.

**Payer** - a State-regulated carrier that issues or delivers health benefit plans in the State and includes: Aetna, Inc.; CareFirst BlueCross BlueShield; CIGNA Health Care Mid-Atlantic Region; Coventry Health Care; Kaiser Permanente; UnitedHealthcare, MidAtlantic Region; and the Maryland State employee and retiree health and welfare benefits program.

**Practice panel** - the patients assigned by a payer to a provider within a primary care practice, or when a payer does not assign patients to a provider within a primary care practice, the number of patients actively enrolled with the payer at the time of the payment request, and who have been treated by the practice within the previous 24 months from the date of the payment request. Payers may exclude patients from the practice panel who are enrolled in a self-insured health plan at the time of the payment request.

**Primary care practice** - a medical practice located in Maryland that is comprised of one or more physicians who provide medical care in family, general, geriatric, internal medicine, pediatric, or gynecologic practice.

**Quality improvement outcomes program** - a program comprised of various nationally endorsed quality improvement indicators which, for the purpose of this incentive program, include indicators regarding the basic adoption and the advanced use of the EHR.

**State-Regulated Payer EHR Adoption Incentive Application Acknowledgement Letter** - a letter sent by the payer to the primary care practice acknowledging receipt of the primary care practice's EHR adoption incentive application.